AB 2071 MOST FREQUENTLY ASKED QUESTIONS

NARCOTIC TREATMENT PROGRAM (NTP) SPECIFIC QUESTIONS

Is there a rate cap for each service component of the NTP rates?

ANSWER: No. Rate caps are for cost reimbursement services such as Outpatient Drug Free (ODF), Day Care Habilitative (DCH), Perinatal Residential (RES), and Naltrexone (NAL). The NTP rate is a fixed rate amount which must be billed, and it includes core services, lab work and dosing. Counseling is the only component which is billed separately and is also a fixed rate in NTPs.

A pregnancy test on a monthly basis is required for child-bearing females on LAAM. Is this service reimbursed?

ANSWER: Yes. The reimbursement of monthly pregnancy tests for LAAM patients is reimbursed through the fixed rate. The costs of all required tests identified on an annual basis were factored in the development of the NTP fixed rates.

Were provider staff costs a consideration in the development of the NTP rate?

ANSWER: Yes. A number of data sources combined with provider feedback assisted in the development of the final amount.

Are take-homes considered a billable day of service?

ANSWER: Yes. All Drug/Medi-Cal (D/MC) eligible Atake-homes@ are billable for D/MC reimbursement for the number of days Atake-homes@ are approved and are provided in compliance with Title 9 requirements. Days on which the patient did not receive either an in-person or take-home dose are not billable days of service.

How are split doses to be billed?

ANSWER: Split doses provided in a single day are considered one dose and should be billed accordingly. The NTP rate was built to include all services provided within a day with the exception of counseling which is billable as separate units of service.

If a methadone dose holds for two days (i.e., the client doses and does not return for

two days), can the dose be billed for two days?

ANSWER: No. Methadone is prescribed for daily use; therefore, dosing of methadone is billed on a daily basis. If a client does not come to the clinic for his/her dose (i.e., no-shows), reimbursement is not allowed for that day.

When is a cost report required? When is a performance report accepted in lieu of a cost report?

ANSWER: The following scenarios outline when an NTP provider would be required to submit a cost report and when they would be required to submit a performance report.

Performance Report Required

X An NTP provider receiving D/MC funds only and providing only NTP services (OMM or LAAM) at the certified site.

Cost Report Required

X An NTP provider receiving D/MC and NNA funds and providing only NTP services (OMM or LAAM) at the certified site.

X An NTP provider receiving D/MC funds only and providing NTP and another D/MC modality (i.e., Outpatient Drug Free, Day Care Habilitative, Perinatal Residential, Naltrexone) at the certified site.

X An NTP provider receiving D/MC and NNA funds and providing NTP and another D/MC modality (i.e., Outpatient Drug Free, Day Care Habilitative, Perinatal Residential, Naltrexone) at the certified site.

When a cost report is required, the cost report must include all of the services provided by the NTP provider.

Can a county/provider be reimbursed at the end of a year from a performance report if payments through the year have been less than the fixed rate amount?

ANSWER: No. A performance report is not a claim for reimbursement. The automated billing system will automatically adjust any NTP claim that is processed to match the fixed rate so payments that are made throughout the year will equal the fixed rate amount.

What are the time requirements in regard to individual and group counseling for NTPs?

ANSWER: An NTP D/MC eligible patient is required to receive a minimum of 50 minutes,

unless waived by the medical director, up to a maximum of two hundred minutes of individual and/or group counseling per calendar month. NTP counseling services shall be billed and reimbursed in 10-minute increments of time for either individual or group counseling.

(NOTE: These time requirements only apply to the NTP modality.)

Since the counseling units of service (UOS) is changing from face-to-face encounters of any duration to 10 minute increments, how does this change affect counseling sessions and billing?

ANSWER: The counselor needs to schedule and manage the therapeutic encounter understanding that the session will be billed in 10 minute increments. Also, to maintain compliance with Title 9 regulations, NTP counseling must be conducted in increments of 10 minutes. The maximum number of 10-minute increments of counseling that can be billed in one calendar month is 20 (200 minutes).

(NOTE: The 10-minute increment requirement for billing and counseling, and the 200 minute counseling maximum per month are only applicable to NTPs.)

GENERAL D/MC QUESTIONS

Does the higher rate for D/MC perinatal services apply only to certified perinatal programs?

ANSWER: Yes. The higher rate for perinatal services only applies to D/MC certified perinatal programs providing enhanced perinatal services to a D/MC eligible beneficiary.

The enhanced perinatal services for D/MC reimbursement as specified in Title 22 are: 1) mother/child habilitative and rehabilitative services; 2) service access; 3) education to reduce harmful effects of alcohol and drugs on the mother and fetus, or the mother and infant; and 4) coordination of ancillary services.

Irrespective of funding source, for NTP providers, Title 9 requires specific treatment services to all pregnant patients. The non-perinatal D/MC rate covers the pregnancy-related services delineated in Title 9.

Are administrative costs associated with the maximum allowance rates for ODF, RES, NAL, and DCH built into the rate?

ANSWER: Yes. The rates for ODF (individual and group), RES, NAL, and DCH are maximum allowable rates which include administrative costs.

Will ADP still accept paper submission of D/MC claims even though a county is automated? Also, if a county has four providers of which two are automated and two continue to submit paper D/MC claims, can the county input the paper provider information on the diskette instead of submitting the paper?

ANSWER: ADP will continue to accept paper submission of D/MC claims. If a county wishes to input data into the automated D/MC billing system for a provider that submits paper D/MC claims to the county, it can, but the county must use a diskette designed for the provider.

Is the Utilization Control Plan (UCP) no longer in effect?

ANSWER: The UCP is effective through June 30, 1997. All services provided to D/MC eligible patients through June 30, 1997, are subject to the requirements of the State UCP. Effective July 1, 1997, Title 22 supersedes the UCP. **This change is effective for all D/MC modalities.** The specific time periods for the performance of treatment services and documentation requirements is specified in Title 22. Also, Title 9 identifies specific time periods and performance of treatment services provided by NTP providers.

Are providers/counties responsible for identifying reasons for disallowances?

ANSWER: Effective July 1, 1997, counties and providers will no longer submit disallowances for patients admitted July 1, 1997 or later. However, providers are responsible for providing services in compliance with Title 22 requirements, as well as the submission of accurate D/MC claims. The specific causes for recovery of payment by ADP are contained in Title 22.

Can group sessions be less than 90 minutes in duration?

ANSWER: Yes. For NTP providers it is not required in Title 9 or Title 22 that a group counseling session must be 90 minutes in duration. However, for ODF programs, 90 minutes for a group counseling session continues to be the basis for the rate maximum. Provision of an average session length of less than 90 minutes results in a proration of that rate.

Is it allowable for a county to continue conducting URC meetings if they have the funding to continue the process and deem it valuable for ensuring quality services at the local level?

ANSWER: Utilization review will be the responsibility of ADP and shall be conducted by ADP effective July 1, 1997, however, counties may continue to have a quality control role as part of its contracting responsibilities. The counties= local quality control program is to be designed and implemented on a local basis.

What funds can be used if the provider=s D/MC costs exceed the maximum allowance for all D/MC modalities?

ANSWER: The maximum allowance is only applicable to ODF, DCH, RES, and NAL D/MC modalities. A fixed rate has been established for NTP providers. The only funds that can be used to cover excess costs above the maximum allowance is county or provider unrestricted funds.

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